

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Washington 19833
Near Clear Spring
Village or City (No.) St.; Ward)

STATE OF MARYLAND CERTIFICATE OF DEATH

 Registration Dist. No. 383

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

 2 FULL NAME Charles Scott Pukeneey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH March 6, 1894
(Month) (Day) (Year)

7 AGE 21 yrs. 8 mos. 11 ds. OR 1 day, hrs. min. ?
It LESS than

8 OCCUPATION
(a) Trade, profession, or particular kind of work farm work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Washington

10 NAME OF FATHER Charles Pukeneey

11 BIRTHPLACE OF FATHER (State or country) Washington

12 MAIDEN NAME OF MOTHER Donnie Speckler

13 BIRTHPLACE OF MOTHER (State or country) Washington

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Donnie Pukeneey

(Address) Clear Spring

15 Filed Nov 19, 1915 Martin Howard
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 17, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1915, to Nov. 17, 1915,

that I last saw him alive on Nov. 16, 1915,

and that death occurred on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) 2 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.
(Signed) Theo. Boose, M. D.
Nov. 19, 1915 (Address) Williamsport Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Paul Cemetery DATE OF BURIAL Nov 20, 1915

20 UNDERTAKER Franky Bros & Co ADDRESS Clear Spring

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

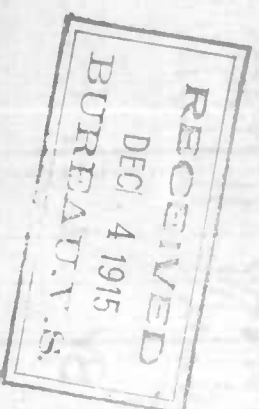
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Conjugal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Washington</u> 19834			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Near Downsville</u> (No. _____)			Registration Dist. No. <u>311</u>		
2 FULL NAME <u>Unnamed Premature Infant (art)</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>M</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>Nov 13</u> , 191 <u>5</u> (Month) (Day) (Year)					
7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>md</u>					
PARENTS	10 NAME OF FATHER <u>Joseph C. Artz</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>md</u>				
	12 MAIDEN NAME OF MOTHER <u>Minnie V. Ridenour</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jos. C. Artz</u> (Address) <u>Hagerstown</u>					
15 FILED <u>Nov 13</u> , 191 <u>5</u> <u>V. M. Richard</u> REGISTRAR <u>racal</u>					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov 13</u> , 191 <u>5</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 13</u> , 191 <u>5</u> , to <u>Nov 13</u> , 191 <u>5</u> , that I last saw him alive on <u>Nov 13</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>6:15</u> a.m.					
The CAUSE OF DEATH* was as follows: <u>Debility due to Premature Birth</u> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory _____ Secondary _____					
(Signed) <u>V. M. Richard</u> , M. D. <u>Nov 13</u> , 191 <u>5</u> (Address) <u>Fair Play</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Manor Cemetery</u>					DATE OF BURIAL <u>Nov 13</u> , 191 <u>5</u>
20 UNDERTAKER <u>Jos. C. Artz</u>					ADDRESS <u>Hagerstown</u>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

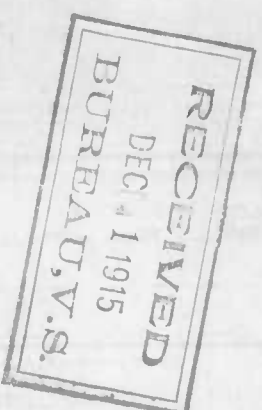
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Fireman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH County <u>Washington</u> 19892 (17200)			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Clear Spring</u> No. _____ St.; _____ Ward)			Registration Dist. No. <u>303</u>		
2 FULL NAME <u>James McClellan Baker</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Negro</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>Unknown</u> , 1 _____ (Month) _____ (Day) _____ (Year)					
7 AGE <u>about 60</u> yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>principally farm work</u>					
9 BIRTHPLACE (State or country) <u>Unknown</u>					
PARENTS					
10 NAME OF FATHER <u>Joshua Baker</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>					
12 MAIDEN NAME OF MOTHER <u>Unknown</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary Baker</u> (Address) <u>Clear Spring</u>					
15 Filled <u>Nov-15-1915</u> <u>Martin Boward</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov. 15th</u> , 191 <u>5</u> (Month) _____ (Day) _____ (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov. 13th</u> , 191 <u>5</u> to <u>Nov. 15th</u> , 191 <u>5</u> , that I last saw him alive on <u>Nov. 15th</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>1 P.</u> m.					
The CAUSE OF DEATH* was as follows: <u>Injury to Spinal Cord from fall, causing paralysis of lower extremities</u> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>Jonathian P. Perry</u> , M. D. <u>Nov 15th</u> , 191 <u>5</u> (Address) <u>Clear Spring Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Bethel Graveyard</u> DATE OF BURIAL <u>Nov 17, 1915</u>					
20 UNDERTAKER <u>Frank Boward</u> ADDRESS <u>Clear Spring</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

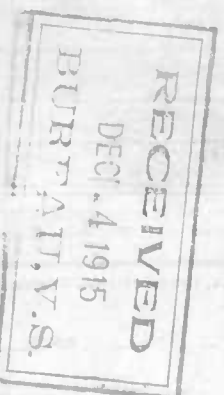
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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County Washington

19835 ✓

(189)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 302Village or City Hagerstown (No. 123, John St St.; 4th Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George C. Beard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDDED
OR DIVORCED
(Write the word)Married

6 DATE OF BIRTH

April 10, 1863
(Month) (Day) (Year)

7 AGE

52 yrs. 7 mos. 18 ds.If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of workLaborer(b) General nature of industry
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Id.10 NAME OF
FATHERGeorge C. Beard11 BIRTHPLACE
OF FATHER
(State or country)Id.12 MAIDEN NAME
OF MOTHERSusan Scarberry13 BIRTHPLACE
OF MOTHER
(State or country)Id.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Margaret Beard(Address) 123 John St

15

Filed

12/1/1915 Henry Davis
191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
my Nov 29, 1915 at 11.30 a.m.
about half hour after his death
that I last saw him alive on Nov 29, 1915
and that death occurred on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH was as follows

Acute Cardiac Failure
found dead in chicken yard in
133 Pine Street, where he had gone about
15 minutes before his death
(Duration) Sudden mos. ds.

Contributory

Secondary

(Signed) Samuel A. Davis, M.D.
(Duration) yrs. mos. ds. 1915
(Address) Hagerstown Id.
M. O.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Smithsburg Id.Dec. 2, 1915

20 UNDERTAKER

ADDRESS

Kraus Bros33 E. Wash St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmionia," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Washington 1915 36 ✓ 64
Village or City Georgetown, Cr. Ringwood & Marshall's St.; 5 Ward
2 FULL NAME Mrs. Fredricka R. Bender
Registration Dist. No. 302
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED widow
(Write the word)

6 DATE OF BIRTH Aug. 14, 1849
(Month) (Day) (Year)

7 AGE 66 yrs. 2 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) "

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Fredrick Schafer

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredricka Wittenau

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John R. Bender

(Address) Baltimore, Md.

15 Filed 4-7-, 1915 Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 7, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1915, to Nov 7, 1915,

that I last saw her alive on Nov 7, 1915, and that death occurred on the date stated above, at 3P m.

The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage

Contributory from attack & condition
Secondary

(Signed) W. E. H. D., M. D.

(Address) 145 N. Washington St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) MANNER OF SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 0 mos. 0 ds. In the State, 1 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death ?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore Md. DATE OF BURIAL 11/8, 1915

20 UNDERTAKER E. M. Suter & Son ADDRESS Georgetown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

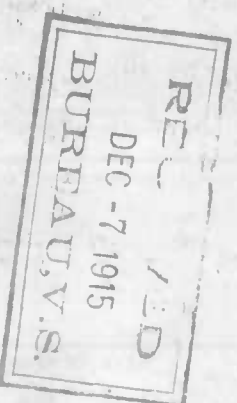
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Mill engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renewed wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Washington 19837

Village or City Benevola (No. _____) St. _____ Ward _____

2 FULL NAME Elizabeth Biser

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 305

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH June 27, 1915
(Month) (Day) (Year)

7 AGE 4 yrs. 24 mos. 24 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Charles L Biser

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Lafols

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles L Biser

(Address) Boonsboro Md

15 Filed Nov. 22, 1915, Geo. W. Stoen, J.P.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 21st, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12th, 1915, to Nov. 20th, 1915,

that I last saw her alive on Nov. 20th, 1915,

and that death occurred on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. J. Smith, M. D.

Nov. 22nd, 1915 (Address) Boonsboro Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Littlestown Cemetery Nov. 22, 1915

20 UNDERTAKER ADDRESS

William F. Best Boonsboro Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia*, ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
DEC. 4 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Washington

19838

(91)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 306

Village or City

Ringgold

(No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ora Paul Bonebrake

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

May 31, 1915
(Month) (Day) (Year)

7 AGE

5 yrs. 0 mos. 0 ds.If LESS than
1 day, _____ hrs.
OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of workat home(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Penna10 NAME OF
FATHERCyrus Bonebrake

PARENTS

11 BIRTHPLACE
OF FATHER
(State or country)Penna12 MAIDEN NAME
OF MOTHERMammie Gody13 BIRTHPLACE
OF MOTHER
(State or country)Penna

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Cyrus Bonebrake

(Address)

Ringgold Md

15

Filed

Nov. 2, 1915J. H. Ferguson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 1, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Oct 31, 1915 to Nov 1, 1915that I last saw him alive on Oct 31, 1915and that death occurred on the date stated above, at 9 o'clock a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia(Duration) 0 yrs. 0 mos. 2 ds.Contributory
Secondary(Duration) 0 yrs. 3 mos. 0 ds.(Signed) S. B. Ferguson, M. D.
Nov. 2, 1915 (Address) Ringgold Md*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDEN-
TAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?Former or
usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Price Cemetery
near Waynesboro Pa 11/3, 1915

20 UNDERTAKER

ADDRESS

A. E. Grove Waynesboro Pa

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. 8. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

19839

✓

104

County

Washington

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

302

Village or City

Rogers

(No. 4)

McHenry

St. 5th

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Luella Carter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE,
MARRIED,
WIDDED,
OR DIVORCED
(Write the word)

Single

DATE OF BIRTH

June 9

(Day)

1915

(Year)

7 AGE

yrs. 5

mos. 1

ds.

It LESS than
1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Va

10 NAME OF FATHER

William Carter

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Linda Drumer

13 BIRTHPLACE OF MOTHER

(State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Luella Carter

(Address)

Rogers

15

Filed

11/12

1915

Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov.

12

1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov. 10

1915

to

Nov. 12

1915

that I last saw him alive on Nov. 10, 1915

and that death occurred on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration)

yrs.

mos.

12 ds.

Contributory
Secondary

Gastro-enteritis

(Duration)

yrs.

mos.

12 ds.

(Signed)

J. B. Laughlin

M. D.

Nov. 12

1915

(Address)

Rogers

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagerway

Nov. 12, 1915

20 UNDERTAKER

ADDRESS

H. K. Coffman

Rogers

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

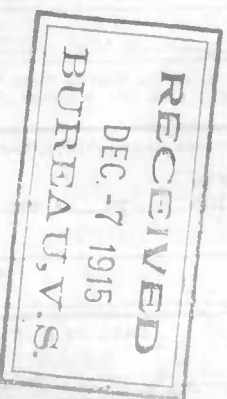
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Washington 19840 ✓ (64)
STATE OF MARYLAND
CERTIFICATE OF DEATH
Registration Dist. No. 302
Village or City Capitol Hill (No. 6 S. Cannon Dist 3 Ward)
2 FULL NAME Ms Caroline Barber
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH Sept. 24, 1845
(Month) (Day) (Year)

7 AGE 70 yrs. 1 mos. 17 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION Housework
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ohio

10 NAME OF FATHER Jonathan Myers

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C. Standman

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Ridgway

(Address) Capitol Hill

15 Filed 11/12, 1915 H. Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 11, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 1, 1915, to Nov 11, 1915,
that I last saw her alive on Nov 10, 1915,
and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH * was as follows:

Cerebral haemorrhage
followed by Paralysis

Contributory Secondary

(Signed) J. M. Deod, M. D.

Nov 11, 1915 (Address) Hagerstown

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rose Hill Cemetery 11/13, 1915

20 UNDERTAKER ADDRESS

E. M. Schuler Hagerstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Riverboat wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *delirium*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
DEC -7 1915
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Washington</u>		19841	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Boonshoo</u> (No. _____) St.; _____ Ward)		(120)	Registration Dist. No. <u>305</u>	
2 FULL NAME <u>Julia Ann Conkling</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 MARRIAGE <u>Widow</u> (Write the word)		
6 DATE OF BIRTH <u>Jan 11, 1814</u> (Month) (Day) (Year)				
7 AGE <u>101</u> yrs. <u>10</u> mos. <u>8</u> ds. If LESS than 1 day, _____ hrs. OR _____ min.?				
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____				
9 BIRTHPLACE (State or country) <u>New York City</u>				
PARENTS	10 NAME OF FATHER <u>William Holcomb</u>	16 DATE OF DEATH <u>Nov 19, 1915</u> (Month) (Day) (Year)		
	11 BIRTHPLACE OF FATHER (State or country) <u>St John's New Brunswick</u>	17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 16, 1915</u> , to <u>Nov 19, 1915</u> , that I last saw her alive on <u>Nov 16, 1915</u> and that death occurred on the date stated above, at <u>8 P</u> m.		
	12 MAIDEN NAME OF MOTHER <u>Julia A Boyce</u>	The CAUSE OF DEATH* was as follows: <u>Ureamic Poisoning</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>New York City</u>	Contributory <u>Interstitial Nephritis</u> (Duration) _____ yrs. _____ mos. _____ ds. Secondary <u>Spiritis</u> (Duration) <u>10</u> yrs. _____ mos. _____ ds. (Signed) <u>F. B. Pondrebaugh</u> , M. D. <u>Nov 21, 1915</u> (Address) <u>Boonshoo Ind</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Edward Conkling</u> (Address) <u>Boonshoo Ind</u>				
15 FILED <u>Nov. 21, 1915</u> <u>Geo. M. Starn, J.P.</u> REGISTRAR				
16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Boonshoo Cemetery</u> DATE OF BURIAL <u>Nov 21, 1915</u>				
20 UNDERTAKER <u>William F. Bait</u> ADDRESS <u>Boonshoo Ind</u>				

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
DEC. 4 1915
BUREAU, V. S.

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1 PLACE OF DEATH Washington **STATE OF MARYLAND**
CERTIFICATE OF DEATH
 County Washington **Registration Dist. No.** 302
Village or City Western Pike, near Cross Pike **St.** — **Ward** —
2 FULL NAME H. Roscoe Cushman [It death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male **4 COLOR OR RACE** White **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Single
 (Write the word)

6 DATE OF BIRTH Nov 8, 1896
 (Month) (Day) (Year)

7 AGE 19 yrs 2 mos 25 ds. **It LESS than 1 day, hrs. min. ?**

8 OCCUPATION
 (a) Trade, profession, or particular kind of work at school
 (b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) MS

10 NAME OF FATHER Wm E Cushman

11 BIRTHPLACE OF FATHER (State or country) MS

12 MAIDEN NAME OF MOTHER Blauche Emmert

13 BIRTHPLACE OF MOTHER (State or country) MS

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm E Cushman

(Address) Western Pike MS

15 11/23, 1915 Henry Davis
 Filled REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 21, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1915 **to** Nov 21, 1915
 that I last saw him alive on Nov 21, 1915

and that death occurred on the date stated above, at 5:30 P. m.
The CAUSE OF DEATH* was as follows:

Bright disease

(Duration) 1 yrs. — mos. — ds.

Contributory Tuberculosis of Spine
Secondary

(Duration) 12 yrs. — mos. — ds.

(Signed) C. R. Schell M. D.
Nov 22, 1915 (Address) 105 N. Potomac St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Hagerstown MS **DATE OF BURIAL** Nov 23, 1915

20 UNDERTAKER A. R. Coppsman **ADDRESS** Hagerstown MS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Hauition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Washington

1984

(5)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 302

Village or City Hagerway (No. _____, St. 1 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Unnamed Child of Bertha & C. S. Daugherty

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Nov 19, 1915
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) C

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER C. S. Daugherty
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Bertha M. Mumford
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. S. Daugherty
(Address) Hagerway

15 Filed 11/20, 1915 Henry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 19, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1915, to Nov. 19, 1915.

that I last saw him alive on _____, 1915.

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Still born
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Heeser, M. D.
11/20, 1915 (Address) Hagerway Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St Paul Cemetery DATE OF BURIAL Nov 20, 1915

20 UNDERTAKER A. Hoffman ADDRESS Hagerway

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

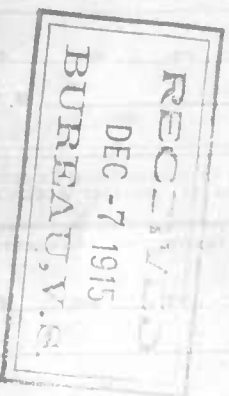
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Washington</u>		19844 ✓	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>2</u> Wash)		Registration Dist. No. <u>302</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Frank M. Bornherger</u>		St. <u>3</u> Ward		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)		
6 DATE OF BIRTH <u>Sept 21</u> , 1880 (Month) (Day) (Year)				
7 AGE <u>35</u> yrs. <u>1</u> mos. <u>16</u> ds. OR <u>1</u> day, <u>1</u> hrs. <u>16</u> min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Carriage Builder</u> (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>md</u>				
PARENTS	10 NAME OF FATHER <u>Henry Bornherger</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>			
	12 MAIDEN NAME OF MOTHER <u>Mary Puschel</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Edwin Duck</u> (Address) <u>Hagerstown Md</u>				
15 Filed <u>11/8-</u> , 191 <u>5</u> <u>Henry Davis</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Nov 6</u> , 191 <u>5</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 6, 1915</u> , at <u>Hagerstown Md</u> , <u>about 8 P. M.</u> , that I last saw him <u>about 8 P. M.</u> and that death occurred on the date stated above, at <u>8 P. M.</u>				
The CAUSE OF DEATH* was as follows: <u>He was found dead in stable located up the alley leading from S. Wallace St. to Queen Anne's Market Wash. & Metropolitan Streets</u> <u>He was admitted to St. Elizabeth's and died of tuberculosis and his death resulted from Effortum and debility.</u> Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.				
(Signed) <u>Samuel W. Spurr J. P.</u> M. D. 191 <u>5</u> (Address) <u>Hagerstown Md</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Hagerstown Md</u>				DATE OF BURIAL <u>Nov 9</u> , 191 <u>5</u>
20 UNDERTAKER <u>A. K. Coffman</u>				ADDRESS <u>Hagerstown Md</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

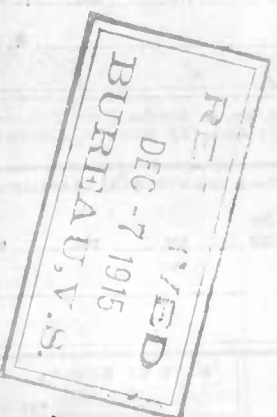
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death); 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Washington</u>			Registration Dist. No. <u>306</u>	
Village or City <u>Near Chewsville</u> (No. <u>170</u>)			St.; Ward)	
2 FULL NAME <u>Jacob L. Extnie Jr</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)		
6 DATE OF BIRTH <u>6</u> <u>23</u> <u>1844</u> (Month) (Day) (Year)				
7 AGE <u>71</u> yrs. <u>5</u> mos. <u>2</u> ds. <u>OR</u> LESS than 1 day.....hrs. <u>OR</u>min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Near Chewsville</u>				
PARENTS	10 NAME OF FATHER <u>Jacob Extnie</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Chewsville</u>			
	12 MAIDEN NAME OF MOTHER <u>Mary Extnie</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Chewsville</u>				MEDICAL CERTIFICATE OF DEATH
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Nate Extnie</u> (Address) <u>Chewsville Md</u>				
15 Filled <u>Nov. 25</u> <u>1915</u> <u>J. H. Ferguson</u> REGISTRAR				
16 DATE OF DEATH <u>Nov.</u> <u>25th</u> <u>1915</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>July 15</u> <u>1915</u> , to <u>Nov. 25th</u> <u>1915</u> , that I last saw him alive on <u>Nov. 24th</u> <u>1915</u> , and that death occurred on the date stated above, at <u>11 30a</u> m.				
The CAUSE OF DEATH* was as follows: <u>Chronic Interstitial Nephritis</u>				
Contributory (Duration) yrs. mos. ds. Secondary <u>Uraemic Coma</u>				
(Signed) <u>J. H. Ferguson</u> , M. D. <u>Nov. 25</u> <u>1915</u> (Address) <u>Chewsville Md</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Leamington Md</u> DATE OF BURIAL <u>Nov. 27</u> <u>1915</u>				
20 UNDERTAKER <u>Geo. B. Hoover</u> ADDRESS <u>Smithsburg</u>				

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

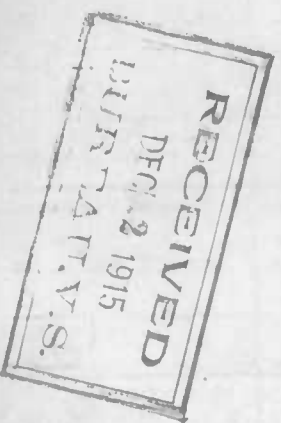
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Washington</u>			Registered No. <u>316</u>	
Village or City <u>Keedysville</u> (No. <u>5</u>)			St.; Ward	
2 FULL NAME <u>James Russell Fisher</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>11</u> (Month) <u>6</u> (Day) <u>1915</u> (Year)				
7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. _____ min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Nine</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>				
9 BIRTHPLACE (State or country) <u>Washington Co.</u>				
PARENTS				
10 NAME OF FATHER <u>James R. Fisher</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Sharpsburg, Md.</u>				
12 MAIDEN NAME OF MOTHER <u>Hattie McLeary</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James R. Fisher</u> (Address) <u>Keedysville, Md.</u>				
15 Filled <u>Mr. J. H. S. Simon</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Mr. 6</u> , 19 <u>15</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Still born</u>				
Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.				
(Signed) <u>J. H. S. Simon</u> , M. D. <u>Mr. 7</u> , 191 <u>5</u> . (Address) <u>Keedysville, Md.</u>				
*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Keedysville, Md.</u>			DATE OF BURIAL <u>11-7</u> , 191 <u>5</u>	
20 UNDERTAKER <u>McGee & Co. Simon</u>			ADDRESS <u>Keedysville, Md.</u>	

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

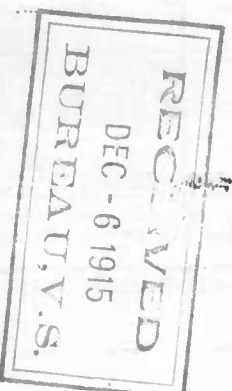
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County

Washington

19847

✓ (119)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

302

Village or City

Hagerstown

(No.)

801

Mulberry

St.;

4th Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Loretta Fore

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Jan 11, 1863
(Month) (Day) (Year)

7 AGE

52 yrs. 9 mos. 25 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Penna.

PARENTS

10 NAME OF FATHER

John A. Snyder

11 BIRTHPLACE OF FATHER (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Elizabeth Hershey

13 BIRTHPLACE OF MOTHER (State or country)

Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Fore

(Address)

Hagerstown Md

15

Filed

11/8-1915 Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 6, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 6, 1915, to Nov 6, 1915.

that I last saw her alive on Nov 6, 1915

and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Brights (?) Based on history only, patient moribund when I was called.

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) M. D. Campbell, M. D.

Nov 7, 1915 (Address) Hagerstown Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagerstown Md

Nov 8, 1915

20 UNDERTAKER

ADDRESS

A. H. Cozzman

Hagerstown Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

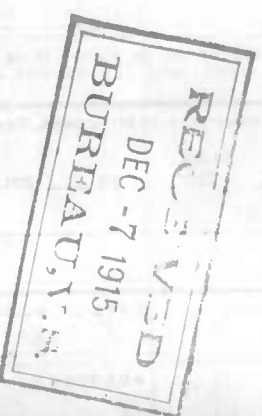
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County WASHINGTON

19848

170

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 300Village or City Near Sharpsburg (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME DANIEL HAMBURGER

PERSONAL AND STATISTICAL PARTICULARS

3 SEX MALE 4 COLOR OR RACE COLORED 5 SINGLE, MARRIED, WIDOWED OR DIVORCED SINGLE
(Write the word)

6 DATE OF BIRTH Unknown
(Month) (Day) (Year)

7 AGE Unknown If LESS than 1 day, ____ hrs. ____ yrs. ____ mos. ____ ds. OR ____ mo. ____ 2

8 OCCUPATION
(a) Trade, profession, or particular kind of work BOATMAN
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) UNKNOWN

PARENTS
10 NAME OF FATHER UNKNOWN
11 BIRTHPLACE OF FATHER (State or country) UNKNOWN
12 MAIDEN NAME OF MOTHER UNKNOWN
13 BIRTHPLACE OF MOTHER (State or country) UNKNOWN

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. R. Renner(Address) Sharpsburg, Md.

15 Filed 11/29/, 1915 Chas. N. Hoffmaster
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH NOV. 29th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, THAT I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

ACCIDENTALLY SHOT BY RIFLE, FROM HIS OWN HAND.

Contributory _____
Secondary _____

(Signed) Chas. N. Hoffmaster, M. D.,
11/29/, 1915 (Address) Sharpsburg, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the ____ State, ____ yrs. ____ mos. ____ ds.
Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL WILLIAMSPORT, Md. DATE OF BURIAL 12/4/, 1915

20 UNDERTAKER Albert Leaf Williamsport ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

gus, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by catholic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

19849

County

Washington

Village or City

White Hall

(No.

St.; Ward)

Registration Dist. No. 304

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James A. Hartle

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

8 20, 1915

(Month) (Day) (Year)

7 AGE

— yrs. 3 mos. 9 ds. OR LESS than 1 day.....hrs. OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Mt. Lima

PARENTS

10 NAME OF FATHER

Arthur J. Hartle

11 BIRTHPLACE OF FATHER (State or country)

Leedsburg

12 MAIDEN NAME OF MOTHER

Lelara E. Detrow

13 BIRTHPLACE OF MOTHER (State or country)

Bourbon

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John A. Hartle

(Address)

Hagerstown P. D.

15

Filed

Nov. 29, 1915 J. H. Ferguson

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 29, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1915, to Nov. 29, 1915.

that I last saw him alive on Nov. 28, 1915.

and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Hereditary Syphilis

(Duration) yrs. 3 mos. 9 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Dr. M. K. Fawcett, M. D.
Nov. 29, 1915 (Address) Leesburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leedsburg Md Nov. 30, 1915

20 UNDERTAKER

ADDRESS

Geo B Hoover Leesburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

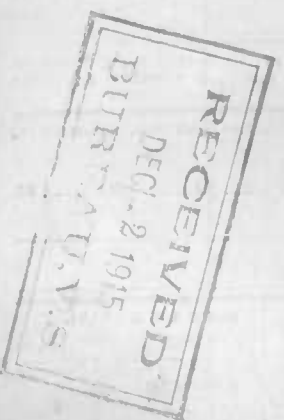
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Washington

19850

✓

154

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

302

Village or City

Hagerstown (No. Western Pike)

St.; — Ward)

If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

Margaret Hearshy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)Widow

DATE OF BIRTH

July 6, 1832
(Month) (Day) (Year)

7 AGE

83 yrs. 4 mos. 19 ds.If LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of workNone(b) General nature of industry
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Md.10 NAME OF
FATHERMartin Spick11 BIRTHPLACE
OF FATHER
(State or country)Md.12 MAIDEN NAME
OF MOTHERNancy Spickler13 BIRTHPLACE
OF MOTHER
(State or country)Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Elizabeth Hearshy

(Address)

Hagerstown Md.

15

Filed

11/27, 1915Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 25, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov 21, 1915, to Nov 25, 1915;that I last saw her alive on Nov 24, 1915;and that death occurred on the date stated above, at 1:30 P.m.

The CAUSE OF DEATH * was as follows:

General debility accompanying
extreme old age

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Signed)

Chas. B. Boyle, M. D.

(Address)

Hagerstown Md.* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL OR HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill11/27, 1915

20 UNDERTAKER

ADDRESS

Mathews & Mumich Hager Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

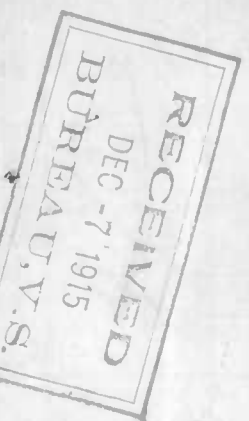
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Branchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carbuncle*, *Sorenia*, etc., of (name origin; "Cancer" is less definite; avoid, use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal pyrexia," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renal wound of head—homicide*; *Poisoned by colic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH, 19851 ✓ ⑤
 County Washington
 Village or City Hagerstown (No. 313 S. Pot St. 2nd Ward)
 2 FULL NAME Unmaimed
 STATE OF MARYLAND
 CERTIFICATE OF DEATH
 Registration Dist. No. 302
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ? 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Nov 9, 1915
 (Month) (Day) (Year)

7 AGE Abortion 3 months If LESS than 1 day, hrs. OR min. ?
 yrs. mos. ds.

8 OCCUPATION
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Md., U. S. A.

10 NAME OF FATHER Alfred G. Humberger

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Pound

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alfred G. Humberger

(Address) Hagerstown Md

15 Filed 11-11- 1915 Henry Davis
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 9, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1915 to Nov 9, 1915

that I last saw him alive on Nov 9, 1915

and that death occurred on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Abortion 3 months

(Duration) yrs. mos. ds.

Contributory ✓
 Secondary

(Duration) yrs. mos. ds.

(Signed) David C. Watkins, M. D.

Nov 9, 1915 (Address) Hagerstown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

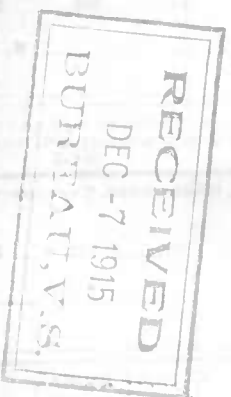
[Approved by U. S. Census and American Public Health
Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u> 19852 ✓ 104			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Kingsdown</u> (No. <u>426</u> , <u>Virginia Ave.</u> St.; <u>2</u> Ward)			Registration Dist. No. <u>2</u>		
2 FULL NAME <u>Richard Gordon Highsmith</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>single</u>			
6 DATE OF BIRTH <u>Mar 26</u> , 191 <u>4</u> (Month) (Day) (Year)					
7 AGE <u>1</u> yrs. <u>7</u> mos. <u>11</u> ds. OR If LESS than 1 day, hrs. min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>"</u>					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>James S. Highsmith</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Kentucky</u>				
	12 MAIDEN NAME OF MOTHER <u>Lillian G. Gordon</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. S. Highsmith</u> (Address) <u>Kingsdown, Md.</u>					
15 Filed <u>11-9-15</u> <u>Henry Davis</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov 7</u> , 191 <u>5</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>one visit</u> , 191 <u>5</u> , to <u>Nov 7</u> , 191 <u>5</u> , that I last saw her alive on <u>Nov 7</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>6:30 p.</u>					
The CAUSE OF DEATH * was as follows: <u>Acute Gastritis</u> (Duration) yrs. mos. ds. Contributory <u>Sudden</u> Secondary <u>Cardiac Exhaustion</u> (Signed) <u>as above</u> , M. O. <u>Nov 8</u> , 191 <u>5</u> (Address) <u>Hogueson</u>					
* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Rose Hill Cemetery</u>					DATE OF BURIAL <u>11/9</u> , 191 <u>5</u>
20 UNDERTAKER <u>Wm. H. H. H. H.</u>					ADDRESS <u>Kingsdown</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Trocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma, Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Thamtion," "Marasmus," "Old Age," "Shock," "Trachma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Retcher wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Washington</u>		19853 ✓	(20)	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>Belleve</u>)		St.; — Ward)		Registration Dist. No. <u>302</u>	
2 FULL NAME <u>George Gahmes</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>			
6 DATE OF BIRTH (Month) (Day) (Year) <u>1839</u>					
7 AGE <u>76</u> yrs. <u>—</u> mos. <u>—</u> ds. If LESS than 1 day, <u>—</u> hrs. OR <u>—</u> min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Md</u>					
PARENTS	10 NAME OF FATHER <u>Unknown</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ben Garrison</u> (Address) <u>Security, Md.</u>					
15 Filed <u>11/19</u> , 191 <u>5</u> <u>Henry Davis</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Mar</u> <u>17</u> , 191 <u>5</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, that I attended deceased from <u>April 1</u> , 191 <u>5</u> , to <u>Mar 17</u> , 191 <u>5</u> , that I last saw him alive on <u>Mar 15</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>9 a.m.</u>					
The CAUSE OF DEATH * was as follows: <u>General exhaustion & debility</u>					
Contributory <u>Fibroid Phthisis</u> Secondary					
(Signed) <u>F. H. Hoffman</u> , M. D. <u>Mar 19</u> , 191 <u>5</u> (Address) <u>Hagerstown Md</u>					
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State, <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Sam'l M. M. Co.</u>				DATE OF BURIAL <u>Mar 20</u> , 191 <u>5</u>	
20 UNDERTAKER <u>Krauss Bros</u>				ADDRESS <u>Hagerstown Md</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

CERTIFICATE OF DEATH

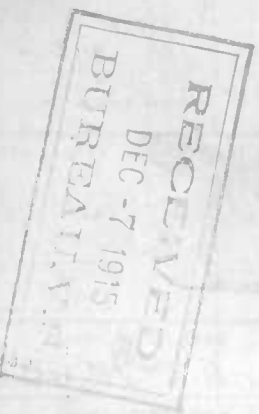
Association.]

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonæum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masks*; *Whooping cough*; *Chronic natural heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Moskos* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Maras-mus," "Old Age," "Shock," "Trachina," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or marriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Reckless wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *hemus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Washington 19854

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 306

Village or City Ringgold (No. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sophia Hoover

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH Nov 1, 1824
(Month) (Day) (Year)

7 AGE 91 yrs. 0 mos. 17 ds. 11 LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

house work

9 BIRTHPLACE (State or country)

Ind

PARENTS
10 NAME OF FATHER Joseph Barkdoll
11 BIRTHPLACE OF FATHER (State or country) Ind
12 MAIDEN NAME OF MOTHER Bathernie Cromer
13 BIRTHPLACE OF MOTHER (State or country) Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Hoover

(Address)

Ringgold Md

15

Filed Nov 20, 1915 J. H. Ferguson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 1914, to _____, 1915.

that I last saw him alive on Nov 18th, 1915.

and that death occurred on the date stated above, at 8:20 p.m.

The CAUSE OF DEATH* was as follows:

Coronary Arteriosclerosis

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Joseph Brothman, M. D.
Nov 20th, 1915 (Address) Smithsburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL River Brethun grave yard DATE OF BURIAL 11/21, 1915

20 UNDERTAKER J. E. & S. ROVE ADDRESS Waynesboro Pa

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

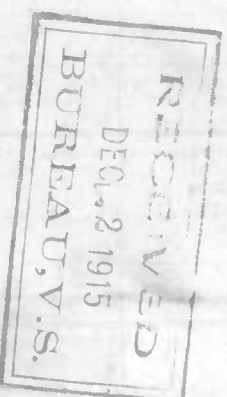
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH County <u>Washington</u>		19855 104		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>310</u>	
Village or City <u>Organ, Md.</u> (No. _____) St.; _____ Ward _____		[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
2 FULL NAME <u>Hanny Armenta Ingram</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)			
6 DATE OF BIRTH <u>10</u> / <u>31</u> / <u>1915</u> (Month) (Day) (Year)		7 AGE _____ yrs. _____ mos. <u>14</u> ds. OR _____ min. ? If LESS than 1 day, _____ hrs.			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Md.</u>					
PARENTS	10 NAME OF FATHER <u>Jesse Ingram</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>May Taylor</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Thomas F. Grimm</u> (Address) <u>Rt. #1, Koppers Ferry, Md.</u>					
15 Filed <u>Nov. 14</u> , 1915					
REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>11</u> / <u>13</u> / <u>1915</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov. 12</u> , 1915, to <u>Nov. 13</u> , 1915, that I last saw him alive on <u>Nov. 13</u> , 1915, and that death occurred on the date stated above, at <u>11.55 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Acute Indigestion</u>					
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>S. Howell Gardner</u> , M. D. <u>11/14</u> , 1915 (Address) <u>Shoemaker's Road</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Simplex Manor, Md.</u>				DATE OF BURIAL <u>Nov. 14</u> , 1915	
20 UNDERTAKER <u>McCarter</u>				ADDRESS <u>Koppers Ferry, Md.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Filed Nov 16 1915, O.H.C. Foundation

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

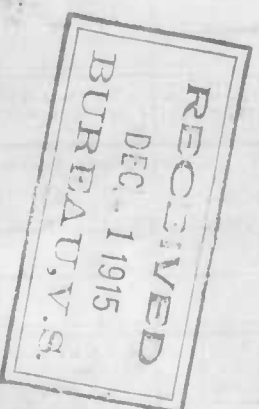
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Turn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 19856

County WashingtonVillage or City Rogersville (No. Wash Co Hospital)Registration Dist. No. 302St. 3rd Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jessie Jackson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Aug. 9, 1898
(Month) (Day) (Year)

7 AGE 17 yrs. 2 mos. 27 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) C

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Charles Butte

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virgine Butler

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. R. Jackson(Address) Leahurst Va

15 Filed 11/8, 1915 Henry Davis
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 6, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1915, to Nov. 6, 1915.

that I last saw her alive on Nov. 6, 1915.

and that death occurred on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Subacute Meningitis

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Typhoid Fever
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Lee M. D., M. D.

1611, 1915 (Address) Rogersville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rogersville Md DATE OF BURIAL Nov 8, 1915

20 UNDERTAKER AN Hoffman ADDRESS Rogersville

back

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

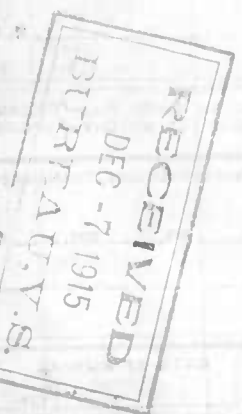
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrub, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Washington</u>		19857	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerston</u> (No. <u>104</u>)		Registration Dist. No. <u>302</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>May. W. E. Jones</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)		
6 DATE OF BIRTH <u>Nov 30</u> , 1915 (Month) (Day) (Year)				
7 AGE <u>5</u> yrs. <u>20</u> mos. <u>20</u> ds. If LESS than 1 day, hrs. OR min.?				
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>MD</u>				
PARENTS	10 NAME OF FATHER <u>Elmer R. Jones</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Boonsboro</u>			
	12 MAIDEN NAME OF MOTHER <u>Esther House</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Frankstown</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Esther House</u> (Address) <u>Hagerstown</u>				
15 Filed <u>11/20</u> , 1915 <u>Henry Davis</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>11</u> — <u>19</u> , 1915 (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 1</u> , 1915, to <u>Nov 18</u> , 1915, that I last saw her alive on <u>Nov 18</u> , 1915, and that death occurred on the date stated above, at <u>3 p.m.</u>				
The CAUSE OF DEATH was as follows: <u>Acute Colitis</u>				
Contributory (Duration) yrs. mos. ds. <u>Cerebral meningitis</u>				
(Signed) <u>H. M. Nihiser</u> , M. D. <u>11-19-1915</u> (Address) <u>Hagerstown Md</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Frankstown Md</u>				DATE OF BURIAL <u>21</u> , 1915
20 UNDERTAKER <u>J. H. Beecher</u>				ADDRESS <u>Frankstown</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Wreck engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic pulmonary heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
DEC -7 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH **Washington** 19858
 County **Washington**
 Village or City **Kandysville Md** (No. **53**) St.; Ward)
 2 FULL NAME **Ann Sophia Knadler**
 Registration Dist. No. **3/6**
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **White** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED **Widow**
 (Write the word)

6 DATE OF BIRTH **4 16 1836**
 (Month) (Day) (Year)

7 AGE **79 yrs. 6 mos. 21 ds.** If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work **None**
 (b) General nature of industry, business, or establishment in which employed (or employer) **None**

9 BIRTHPLACE (State or country) **Md**

PARENTS
 10 NAME OF FATHER **John Carr**
 11 BIRTHPLACE OF FATHER (State or country) **Md**
 12 MAIDEN NAME OF MOTHER **Matilda Baker**
 13 BIRTHPLACE OF MOTHER (State or country) **Md**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **E Baker Knadler**

(Address) **Kandysville Md**

15 Filed **Nov 9 1915** **55 H H Sumner**

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **Nov 7 1915**
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **June 1915** to **Nov 7 1915**

that I last saw him alive on **Nov 7 1915**

and that death occurred on the date stated above, at **102, m.**

The CAUSE OF DEATH* was as follows:

General Senility

(Duration) yrs. mos. ds.
 Contributory **Winkler Encephalitis**
 Secondary

(Signed) **H H Sumner M. D.**
Nov 9 1915 (Address) **Kandysville Md**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL **Kandysville Md** DATE OF BURIAL **11-10-1915**

20 UNDERTAKER **C L Sumner & Co** ADDRESS **Kandysville Md**

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.* Never report *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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REC'D
DEC - 6 1915
BUREAU, V. S.

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1 PLACE OF DEATH
County Washington

Village or City Mercersville (No. _____, St.; Ward _____)

2 FULL NAME Dorothy M. Knode

19859

152

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 311

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Oct 24 1915
(Month) (Day) (Year)

7 AGE 29 yrs. — mos. — ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Mercersville

PARENTS
10 NAME OF FATHER Harry Knode
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Ella M. Speaker
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ella Knode

(Address) Sharpsburg, Md.

15 Filed Nov 23 1915 D. M. Reichard
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 23 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 17 1915 to Nov 23 1915,

that I last saw her alive on Nov 22 1915,

and that death occurred on the date stated above, at 12 noon m.

The CAUSE OF DEATH * was as follows:

bronchitis

(Duration) yrs. mos. 4 ds.

Contributory Inflammation of
Secondary Amphibolus

(Signed) D. M. Reichard, M. D.
Nov 23 1915 (Address) Fair Play Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bakersville DATE OF BURIAL Nov 24 1915

20 UNDERTAKER D. M. Reichard ADDRESS Fairplay Ind.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

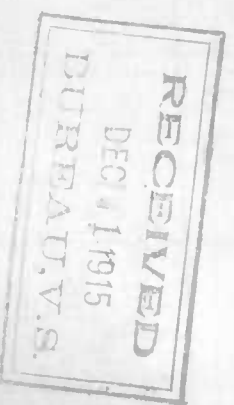
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicaemia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Washington 19860

(15)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 301Village or City Near Williamsport (No. 15)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Francis Longuecker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word)6 DATE OF BIRTH Nov. 25, 1915
(Month) (Day) (Year)7 AGE — yrs. — mos. — ds. IF LESS than 1 day, // hrs. OR — min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) None9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Chas Longuecker11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Mary Summers13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Summers(Address) Williamsport Md15 Filed Nov 27, 1915 E. Rickard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 25, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1915, to Nov. 25, 1915,that I last saw her alive on Nov. 25, 1915, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH * was as follows:

Perinatal BirthContributory Euphuemia (Duration) — yrs. — mos. — da.
Secondary(Signed) E. S. Rickard M. O.
Nov. 26, 1915 (Address) Williamsport Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State, — yrs. — mos. — da.
Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Williamsport Md DATE OF BURIAL Nov. 27, 191520 UNDERTAKER Albert Lee Williamsport ADDRESS Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

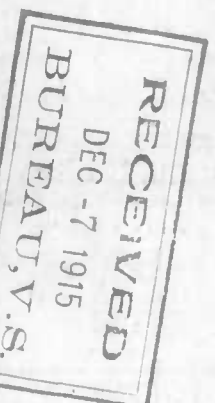
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Truism," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renal wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Washington 19861 ✓ (151)
STATE OF MARYLAND
CERTIFICATE OF DEATH
Registration Dist. No. 302
Village or City Hagerstown (No. 49, Elizabeth St.; 3rd Ward)
[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME Charles Edward Rutman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED single.
(Write the word)

6 DATE OF BIRTH Oct 21st, 1915
(Month) (Day) (Year)

7 AGE 14 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) "

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Walter Rutman

11 BIRTHPLACE OF FATHER (State or country) West Va.

12 MAIDEN NAME OF MOTHER Helma Randall

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Rutman

(Address) Hagerstown Md.

15 Filed 11/5, 1915 Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 4, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1915, to Nov. 4, 1915.

that I last saw him alive on Nov 3, 1915.

and that death occurred on the date stated above, at 7 a. m.

The CAUSE OF DEATH * was as follows:

Premature birth - (26 mo.)

(Duration) — yrs. — mos. — ds.

Contributory
Secondary

(Signed) Henry Davis, M. D.

11/4, 1915 (Address) Hagerstown Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — ds. to the State, — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Pop Hill Cemetery DATE OF BURIAL 11/5, 1915

20 UNDERTAKER Walter Rutman ADDRESS Hagerstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

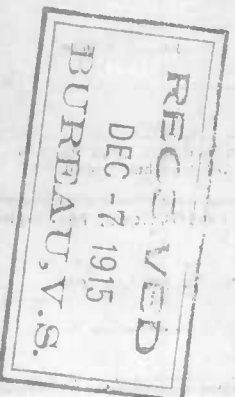
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Trocity*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Reckless wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered, in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH 19862
 County Washington (95)
 Village or City Millstone (No. _____ St.; _____ Ward)
 2 FULL NAME John M^c Kee

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 304

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Feb. 2, 1849
 (Month) (Day) (Year)

7 AGE 66 yrs. 9 mos. 13 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Whips Cove Parr

10 NAME OF FATHER William McKee

11 BIRTHPLACE OF FATHER (State or country) Not known

12 MAIDEN NAME OF MOTHER Zillah Blankley

13 BIRTHPLACE OF MOTHER (State or country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) W. R. Daniels
 (Address) Hancock Md.

15 Filled Nov 10, 1915 J. P. Jenkins
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 12, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 9th, 1915, to Nov 12th, 1915, that I last saw him alive on Nov 14th, 1915

and that death occurred on the date stated above, at 8:30 A. m.
 The CAUSE OF DEATH* was as follows:

Pneumonia
 (Duration) _____ yrs. _____ mos. 9 ds.

Contributory _____
 Secondary _____
 (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. S. S. S., M. D.
11/15, 1915 (Address) Hancock Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Little Core M. E. DATE OF BURIAL Nov. 18, 1915

20 UNDERTAKER Albert K... ADDRESS Sylva...

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

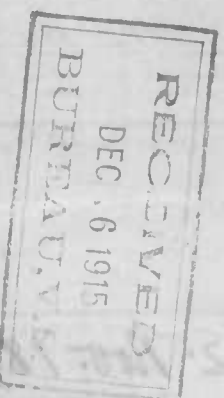
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
 County Washington 19863 ✓ (170)
STATE OF MARYLAND
CERTIFICATE OF DEATH
 Registration Dist. No. 302
 Village or City Hagerstown (No. 41 W. Church St.; 5 Ward) [It death occurred to a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME Robert B. Mackey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male **4 COLOR OR RACE** colored **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Widower
 (Write the word)

6 DATE OF BIRTH Dec 20, 1847
 (Month) (Day) (Year)

7 AGE 67 yrs. 10 mos. 28 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
 (State or country) Maryland

10 NAME OF FATHER Lloyd Mackey

11 BIRTHPLACE OF FATHER
 (State or country) MD.

12 MAIDEN NAME OF MOTHER Mary Wagner

13 BIRTHPLACE OF MOTHER
 (State or country) MD.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Cora Fletcher

(Address) Hagerstown MD

15 Filed 11/18-, 1915 Henry Davis
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 16th, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 5th, 1915, to Nov 16th, 1915, that I last saw him alive on Nov 14th, 1915

and that death occurred on the date stated above, at 7-0 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 1 yrs. mos. ds.

Contributory Arteriosclerosis, general
 Secondary debility

(Duration) 2 yrs. mos. ds.

(Signed) W. H. Page, M. D.
Nov 18th, 1915 (Address) Hedgesboro

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Half Way MD

DATE OF BURIAL Nov 18, 1915

20 UNDERTAKER A. R. Coffman

ADDRESS Hagerstown MD

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

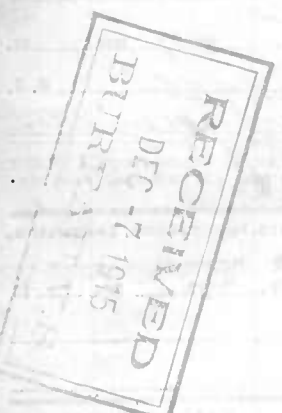
[Approved by U. S. Census and American Public Health
Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Washington

19864

151

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

305

Village or City

Annoestown

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

7 Bruce Marshall

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Nov. 26, 1915

(Month)

(Day)

(Year)

7 AGE

m yrs. m mos. 2 1/2 ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Nurse

(b) General nature of industry business, or establishment in which employed (or employer)

Nurse

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Frank Marshall

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Grace Harshman

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Marshall

(Address)

Beaver Creek Inc.

15

Filed

Nov. 29, 1915

J. M. Storr, Jr.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 28, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 26, 1915, to Nov. 28, 1915,

that I last saw h. alive on

Nov. 27, 1915,

and that death occurred on the date stated above, at 3 m.

The CAUSE OF DEATH * was as follows:

Congenital Weakness

Contributory

Cardiac Failure

Secondary

(Signed)

J. M. Wragaman, M. D.

Nov. 28, 1915 (Address) Hagerstown Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Annoestown County

Nov. 29, 1915

20 UNDERTAKER

ADDRESS

William F. Best Boonshov Inc.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
DEC. 4 1915
BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Washington
Village or City Hagerstown (No. 526 Summit Ave. 2" Ward)
2 FULL NAME William M. Melester
STATE OF MARYLAND
CERTIFICATE OF DEATH
Registration Dist. No. 302
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Mar. 29, 1871
(Month) (Day) (Year)

7 AGE 44 yrs. 7 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Wreck Master.
(b) General nature of industry, business, or establishment in which employed (or employer) W. M. R. R. Co.

9 BIRTHPLACE (State or country) Penn.

10 NAME OF FATHER William Melester

11 BIRTHPLACE OF FATHER (State or country) Penn.

12 MAIDEN NAME OF MOTHER Eva. Gutschall

13 BIRTHPLACE OF MOTHER (State or country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Unseld

(Address) 526 Summit Ave.

15 Filed 11/24, 1915 Henry Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 22, 1915
(Month) Nov (Day) 22 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1895 to Nov. 22, 1915
that I last saw him alive on Nov. 22, 1915

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH * was as follows:

Angina pectoris
(Duration) yrs. mos. 1 hrs.

Contributory Articulation of
Secondary affection of (Duration) yrs. mos. ds.

(Signed) Chas. H. Hager M. D.
Nov. 23, 1915 (Address) Hagerstown, Md.

*State the DISEASE CAUSING DEATH, or, if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rose Hill Cemetery DATE OF BURIAL 11/24, 1915

20 UNDERTAKER Wm. H. Hager ADDRESS Hagerstown, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

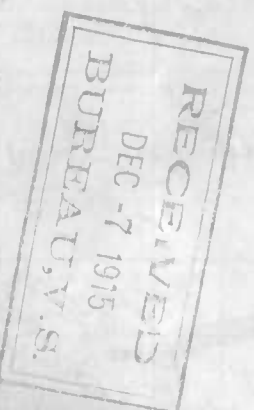
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Deputy," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis*.

gas, peritonaeum, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Washington

19866

104

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 811Village or City near Bethesda (No. _____)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Carl M. Metz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH 7 (Month) 15 (Day) 1915 (Year)

7 AGE 3 yrs. 21 mos. 21 ds. If LESS than 1 day, hrs. OR mo. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Victor Metz

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 M maiden NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Victor M. Metz(Address) Bethesda Md

15 Filed Nov 6, 1915 S. D. M. Reichard Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 5th, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from Oct. 30th, 1915, to Nov 5th, 1915,

that I last saw him alive on Nov 5th, 1915,

and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH * was as follows:

Acute Enteritis
with Emaciation

(Duration) yrs. mos. 20 ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) J. Hubert M. L., M. D.
Nov 6th, 1915 (Address) Brownson Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Manor Cemetery DATE OF BURIAL Nov 7th, 1915

20 UNDERTAKER Norman Reichard ADDRESS Fairplay Rd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

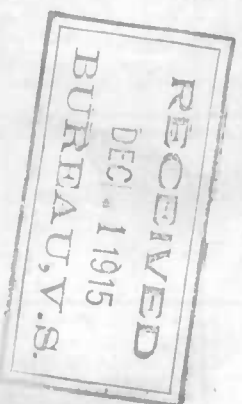
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonymy is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS or INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Washington (28) ✓
Village or City Hagerstown (No. 42, Broadway St.; 4 Ward)
2 FULL NAME John H. Mc Miller
Registration Dist. No. 302
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)
6 DATE OF BIRTH Aug 7, 1857
(Month) (Day) (Year)
7 AGE 58 yrs. 3 mos. 3 ds. IT LESS THAN 1 day... hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Md

PARENTS
10 NAME OF FATHER Eli Mc Miller
11 BIRTHPLACE OF FATHER (State or country) Penna
12 MAIDEN NAME OF MOTHER Katherine Walker
13 BIRTHPLACE OF MOTHER (State or country) Penna

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. R. Mc Miller
(Address) Hagerstown Md

15 Filed 11/10, 1915 Berry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 10th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1915, to Nov. 10th, 1915,

that I last saw him alive on Nov. 10th, 1915,

and that death occurred on the date stated above, at 10:10 a m.

The CAUSE OF DEATH * was as follows:

Relapsing Malaria

(Duration) 3 yrs. 3 mos. 3 ds.
Contributory Pulmonary Tuberculosis
Secondary

(Signed) J. H. Miller (Duration) 30 yrs. 30 mos. 30 ds.
Nov 10th, 1915 (Address) Hagerstown
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death Nov 10th yrs. 30 mos. 30 ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rose Hill DATE OF BURIAL 11/2, 1915
20 UNDERTAKER Matthews Minnich ADDRESS Hag. Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

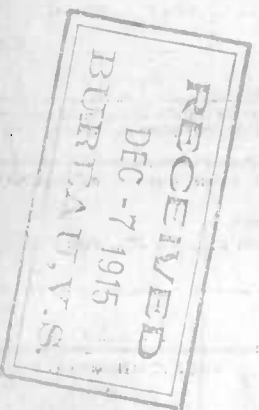
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Fireman*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

gus, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congrital," "Senile," etc.), "Tropxy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as, fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 19868
 County Washington Co.
 Village or City Hagerstown (No. 5 Main Ave St.; 2nd Ward)
 Registration Dist. No. 302
 2 FULL NAME Stell Birth
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE M 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH Nov. 22, 1915
 (Month) (Day) (Year)

7 AGE 4 mo. 4 weeks If LESS than 1 day, hrs. OR min. ?
 yrs. mos. ds.

8 OCCUPATION
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Wash. Co. Maryland

PARENTS
 10 NAME OF FATHER Harry H. Morgan
 11 BIRTHPLACE OF FATHER (State or country) Illinois
 12 MAIDEN NAME OF MOTHER Laura Butler
 13 BIRTHPLACE OF MOTHER (State or country) W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry H. Morgan
 (Address) Harry H. Morgan

15 Filed 11/23, 1915 Henry Davis
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4 Nov. 1915 Stell Birth, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
 _____, 191____, to _____, 191____,

that I last saw him alive on _____, 191____,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

Stell Birth from
thrombocytopenic purpura - Cause
unknown (Duration) yrs. mos. ds.

Contributory
 Secondary

(Signed) J. M. Hutter M. D.
Nov. 23, 1915 (Address) Hagerstown

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hagerstown, Md. DATE OF BURIAL 11/23, 1915

20 UNDERTAKER Father ADDRESS Hagerstown, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

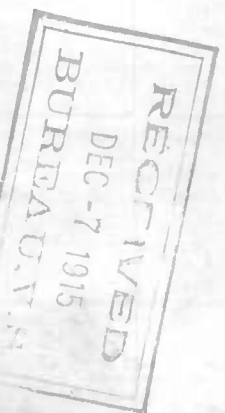
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Washington

19869

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 302

Village or City Hagerstown (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME None

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH 11 16, 1915
(Month) (Day) (Year)

7 AGE _____ If LESS than 1 day, 2 hrs. _____ yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER Lafayette Jno. Murray

11 BIRTHPLACE OF FATHER (State or country) Washington Co.

12 MAIDEN NAME OF MOTHER Julia Viola Hull

13 BIRTHPLACE OF MOTHER (State or country) Washington Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. J. Murray

(Address) Hagerstown Md.

15 Filed 11/18, 1915 Harry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 16, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1915, to Nov 16, 1915,

that I last saw him alive on Nov 16, 1915

and that death occurred on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Premature Delivery
(4 months gestation)
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. D. Campbell, M. D.

Nov. 18, 1915 (Address) Hagerstown Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hagerstown, Md. 11/18, 1915

20 UNDERTAKER ADDRESS

Father Hagerstown, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

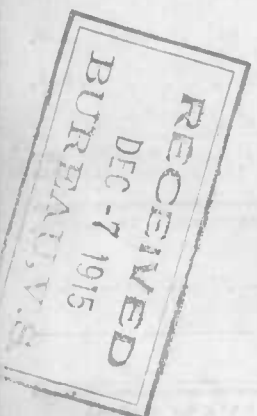
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH			STATE OF MARYLAND	
County <u>Harlington</u> 19893			CERTIFICATE OF DEATH	
Village or City <u>Leavetown</u> (No. _____)			Registration Dist. No. <u>306</u>	
2 FULL NAME <u>Isabell Plummer</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>		
6 DATE OF BIRTH <u>10</u> <u>28</u> <u>1837</u> (Month) (Day) (Year)				
7 AGE <u>78</u> yrs. <u>—</u> mos. <u>10</u> ds. IF LESS than 1 day, ____ hrs. OR ____ min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____				
9 BIRTHPLACE (State or country) <u>Near Leavetown</u>				
PARENTS	10 NAME OF FATHER <u>Nicholas Beard</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Near Leavetown</u>			
	12 MAIDEN NAME OF MOTHER <u>Nancy Martle</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Mash Co.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Leathomic Houser</u> (Address) <u>Leavetown</u>				
15 Filed <u>Nov. 8</u> , 1915 <u>J. H. Ferguson</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Nov 8th</u> , 1915 (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from _____, 1915, to _____, 1915, that I last saw her alive on <u>Nov 1st</u> , 1915, and that death occurred on the date stated above, at <u>7</u> A.M. The CAUSE OF DEATH* was as follows: <u>Pulmonary Hemorrhage</u> (Duration) _____ yrs. _____ mos. _____ ds.				
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.				
(Signed) <u>Joseph Protzman, M. D.</u> <u>Nov. 8</u> , 1915. (Address) <u>Smithsburg, Md.</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Smithsburg Cemetery</u>				DATE OF BURIAL <u>Nov 11th</u> , 1915
20 UNDERTAKER <u>Ceo B. Hoover</u>				ADDRESS <u>Smithsburg</u>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

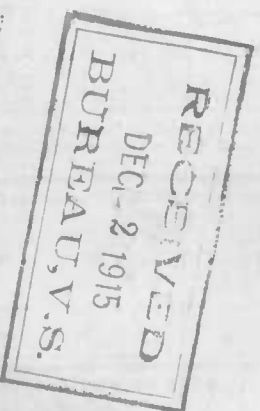
[Approved by U. S. Census and American Public Health Association.]

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19870

1 PLACE OF DEATH
County Washington

Village or City Hagerstown (No. 106 Fairgrove St. 4 Ward) 157

2 FULL NAME Samuel Powell

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower
(Write the word)

6 DATE OF BIRTH Aug 26, 1835
(Month) (Day) (Year)

7 AGE 80 yrs. 3 mos. — ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Pa.

PARENTS

10 NAME OF FATHER James Powell

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Bemestouffer

13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clinton Powell
(Address) Hagerstown, Md

15 Filed 11/27, 1915 Henry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 26, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 26 1915, at 11.15 a.m., 1915, that I last saw him about one hour after death occurred alive on, 1915, and that death occurred on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:
by strangulation from hanging with a rope around his neck in stable of 106 Fairgrove Ave in Hagerstown Md
(Duration) yrs. mos. ds.

Contributory _____
Secondary _____
(Duration) yrs. mos. ds.

(Signed) Samuel W. Smith & P. M. D.
acting coroner
1915 (Address) Hagerstown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Hagerstown, Md DATE OF BURIAL Nov 28, 1915

20 UNDERTAKER G. P. Coffman ADDRESS Hagerstown, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

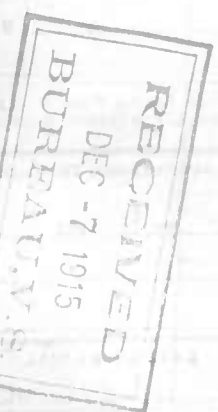
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

1 PLACE OF DEATH 19871 ✓
 County Washington
 Village or City Hagerstown (No. Suters Alley St. 5th Ward) 80
 2 FULL NAME John Redman

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married
 (Write the word)

6 DATE OF BIRTH June 1, 1853
 (Month) (Day) (Year)

7 AGE 62 yrs. 5 mos. 25 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Labourer
 (b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Va.

10 NAME OF FATHER Samuel Redman

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER No Record

13 BIRTHPLACE OF MOTHER (State or country) No Record

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Redman

(Address) Hagerstown Md

15 Filed 11/27 1915 Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 26, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from No 26, 1915, to Nov 26, 1915.

that I last saw him alive on Dead when called, 1915.

and that death occurred on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Family Statement Says V. D. C. P. for 10 yrs. Pneumonia Complicated with appearance of disease
 (Duration) ____ yrs. ____ mos. ____ ds.

Contributory
 Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. E. Coffey, M. D.

11/27, 1915 (Address) Hagerstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. in the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hagerstown Md

DATE OF BURIAL Nov 28, 1915

20 UNDERTAKER C. R. Coffman

ADDRESS Hagerstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

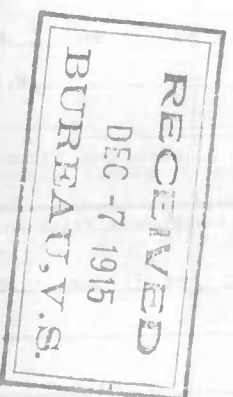
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples; *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH Washington 19872
 County Washington
 Village or City Near Smithsburg (No. _____) St.; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John H. RoweRegistration Dist. No. 306

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH 2 11 1909
 (Month) (Day) (Year)

7 AGE 9 yrs. 9 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Near Smithsburg10 NAME OF FATHER Walter M. Rowe11 BIRTHPLACE OF FATHER (State or country) Calaylick Pa12 MAIDEN NAME OF MOTHER Eda Hoffman13 BIRTHPLACE OF MOTHER (State or country) Bagertown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M. Rowe(Address) Smithsburg Md

15 Filed Nov. 26, 1915 J. M. Ferguson
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 25, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1915, to Nov. 25, 1915

that I last saw him alive on Nov. 25, 1915

and that death occurred on the date stated above, at 9 P m,

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) _____ yrs. _____ mos. 15 ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Do not Refuse, M. D.

Nov. 25, 1915 (Address) Smithsburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Stetys Graveyard Nov 26, 1915

20 UNDERTAKER ADDRESS

Geo. B. Hoover Smithsburg Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

19873

County

Washington

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

302

Village or City

Rogersville (No. 129, Elm

St. 3rd Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Unnamed child

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Nov 22, 1915

7 AGE

— yrs. — mos. — ds. OR — min. ?

If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

James H. Sagle

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary E. Dussang

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James H. Sagle

(Address)

Rogersville, Md.

15

Filed

11/22, 1915

Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 22, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

191

and that death occurred on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Still - birth
Deformed child

(Duration)

yrs.

mos.

ds.

Contributory

Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

J. R. Laughlin, M. D.

Nov 22, 1915

(Address)

Rogersville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Scratch Church

Nov 22, 1915

20 UNDERTAKER Frederick L. ...

ADDRESS

A. Hoffman

Rogersville, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

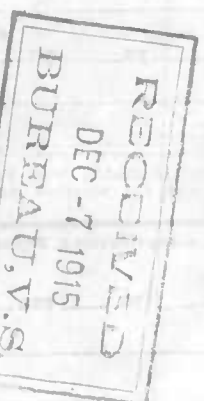
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Washington</u>			Registration Dist. No. <u>302</u>	
Village or City <u>Hagerstown</u> No. <u>Wash. C. Hospital</u> St. <u>3</u> Ward			[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Guy A. Saunders</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>married</u> (Write the word)		
6 DATE OF BIRTH <u>Jan 22, 1889</u> (Month) (Day) (Year)				
7 AGE <u>26</u> yrs. <u>9</u> mos. <u>20</u> ds. If LESS than 1 day, hrs. OR min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>R. R. Conductor</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>W. M. R. R. Co.</u>				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
PARENTS	10 NAME OF FATHER <u>John Martin</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
	12 MAIDEN NAME OF MOTHER <u>Sus. Hurlbault</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. G. A. Saunders</u> (Address) <u>Hagerstown Md</u>				
15 Filed <u>11/14</u> , 191 <u>5</u> <u>Henry Davis</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>November 12</u> , 191 <u>5</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>November 12</u> , 191 <u>5</u> , to <u>Nov 12</u> , 191 <u>5</u> , that I last saw him alive on <u>Nov 12</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>3:25</u> p.m.				
The CAUSE OF DEATH * was as follows: <u>Crushed arm (RT) and crushed leg (RT). Railroad accident.</u>				
18 (Duration) <u>several hours</u> yrs. mos. ds.				
Contributory Secondary (Duration) yrs. mos. ds.				
(Signed) <u>Regina North</u> , Cor., M. O. <u>Nov. 13, 1915</u> (Address) <u>Hagerstown</u>				
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.				
19 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Good Will Cemetery</u>				DATE OF BURIAL <u>11/15</u> , 191 <u>5</u>
20 UNDERTAKER <u>B. M. Suter</u>				ADDRESS <u>Hagerstown</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

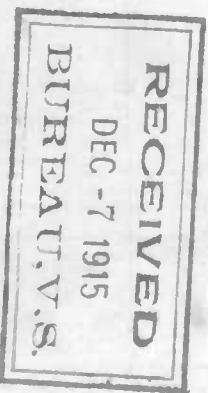
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Washington

19875

(170)

Village or City

Sharpsburg

(No.

St.;

Ward)

Registration Dist. No. 300

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Daniel Saylor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

widowed

6 DATE OF BIRTH

Dec 17, 1860
(Month) (Day) (Year)

7 AGE

54 yrs. 11 mos. 11 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed (or employer)

Boatman

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Edward Saylor

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MOTHER NAME OF MOTHER

Matilda Hewitt

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Benjamin Saylor

(Address)

Samples Manor

15

Filed 11/30/1915 Ches. N. Hoffmaster

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 28, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

for years, 191, to Nov. 28, 1915, that I last saw him alive on Nov. 28, 1915, and that death occurred on the date stated above, at 10.0 a.m.

The CAUSE OF DEATH was as follows:

Chronic nephritis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

E. M. Gussow, M. D.

Nov. 30, 1915

(Address) Sharpsburg, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sharpsburg Md Dec 1, 1915

20 UNDERTAKER

ADDRESS

Albert Lee Williamsport Md

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RECEIVED
DEC - 7 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH <u>19877</u>		STATE OF MARYLAND	
County <u>Washington</u>		CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>801</u> , S. <u>Polomac</u> St., <u>2nd</u> Ward)		Registration Dist. No. <u>302</u>	
2 FULL NAME <u>John H. Seaman</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>Dec 21</u> , 18 <u>63</u> (Month) (Day) (Year)			
7 AGE <u>51</u> yrs. <u>10</u> mos. <u>20</u> ds.		If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>			
9 BIRTHPLACE (State or country) <u>md.</u>			
PARENTS	10 NAME OF FATHER <u>George W. Seaman</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>md.</u>		
	12 MAIDEN NAME OF MOTHER <u>Sarah Ann Mc Caffrey</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>U. S.</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs John Seaman</u> (Address) <u>Hagerstown, Md</u>			
15 Filed <u>11/13</u> , 191 <u>5</u> <u>Henry Davis</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Nov 11</u> , 191 <u>5</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>June 15</u> , 191 <u>5</u> , to <u>Nov. 11</u> , 191 <u>5</u> , that I last saw him alive on <u>Nov. 11</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>3 p.m.</u> The CAUSE OF DEATH* was as follows: <u>Tuberculosis of Lungs</u> <u>Cardiac Failure</u> (Duration) <u>7</u> yrs. <u>6</u> mos. <u>—</u> ds. Contributory Secondary (Duration) <u>—</u> yrs. <u>—</u> mos. <u>10</u> ds. (Signed) <u>A. M. Wagoner</u> , M. D. <u>Nov 11</u> , 191 <u>5</u> , (Address) <u>Hagerstown Md</u>			
*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Hagerstown, Md</u>		DATE OF BURIAL <u>Nov 13</u> , 191 <u>5</u>	
20 UNDERTAKER <u>A. R. Coffman</u>		ADDRESS <u>Hagerstown</u>	
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.			

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

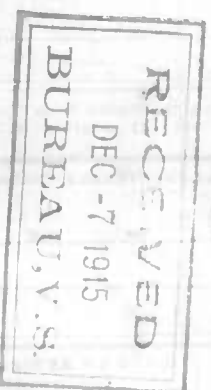
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH
County Washington 19878

Village or City Pondville (No. 189) St.; Ward)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 306

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Harry Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH 5-18-1915
(Month) (Day) (Year)

7 AGE 5 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Smithsburg Md

10 NAME OF FATHER John H. Smith

11 BIRTHPLACE OF FATHER (State or country) near Pondville

12 MAIDEN NAME OF MOTHER Mary Kuhn

13 BIRTHPLACE OF MOTHER (State or country) Pondville

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Smith

(Address) Pondville

15 Filed Nov. 18, 1915 J. H. Ferguson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from I did not attend, 1915, to see medicine, 1915, in the 17th never saw it.
that I last saw him alive on Nov. 17, 1915, 1915

and that death occurred on the date stated above, at 11 m.

The CAUSE OF DEATH * was as follows:

purely neglect from the time it was born.

neglect and want of care and treatment
(Duration) yrs. mos. ds.

Contributory It isn't really anyone's
Cause for no physician saw it.
(Duration) yrs. mos. ds.

(Signed) Supposed to have died yesterday, M. O. morning
Nov. 18, 1915 (Address) J. L. Massie, M.D.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death Nov. 18, 1915 yrs. mos. ds. In the State, Nov. 18, 1915 yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Smithsburg Md DATE OF BURIAL Nov 19th, 1915

20 UNDERTAKER Geo B Hoover ADDRESS Smithsburg Md

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Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Baltimore 19879
Village or City Eckles Mills (No. 5) St. _____ Ward _____

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 316

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Not named

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Nov 15, 1915
(Month) (Day) (Year)

7 AGE _____ It LESS than 1 day _____ hrs. _____ yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) MD

PARENTS
10 NAME OF FATHER Harvey M. Dwyer
11 BIRTHPLACE OF FATHER (State or country) MD
12 MAIDEN NAME OF MOTHER Pearl Green
13 BIRTHPLACE OF MOTHER (State or country) Starks Florida

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harvey M. Dwyer
(Address) P.O. Judyville

15 Filed Nov 20, 1915 H. H. Seimann
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 15, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw him _____ alive on _____, 191____.

and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Shell bomb about 3 hrs
after

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. H. Seimann, M. D.

Nov 15, 1915 (Address) Judyville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St. Pauline DATE OF BURIAL Nov 15, 1915

20 UNDERTAKER Harvey M. Dwyer ADDRESS Judyville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

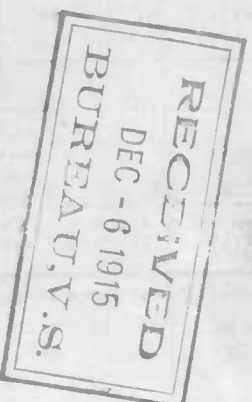
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Washington

19880

✓ (5)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 302Village or City Hagerstown (No. 711, 2 Loaned St.; 4th Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Still born

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ? 4 COLOR OR RACE white 5 SINGLE, ~~MARRIED~~ Remains
~~WIDOWED~~
~~OR DIVORCED~~
(Write the word) single

6 DATE OF BIRTH 11 6 1915
(Month) (Day) (Year)

7 AGE Still born If LESS than 1 day, ____ hrs. ____ yrs. ____ mos. ____ ds. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Hagerstown

PARENTS
10 NAME OF FATHER Joseph C Snyder
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Lily Blyers
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph C Snyder
(Address) Hagerstown

15 Filed 11-6-, 1915 Henry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11-6, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

Still born
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary Not known
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Wm Preston Miller
11-6, 1915 (Address) Hagerstown

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) TRANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Rocery*; (a) *Foreman*, (b) *Automobile factory*. The material written on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Peeler," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Branchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Washington 19881STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 302Village or City Hagerstown (No. 535, S. Potomac St. St.; 2nd Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ezra Spielman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)Widowed

6 DATE OF BIRTH

Dec 1, 1845
(Month) (Day) (Year)

7 AGE

78 yrs. 11 mos. 15 ds.If LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

John Spielman11 BIRTHPLACE OF FATHER
(State or country)Md

12 MAIDEN NAME OF MOTHER

Mary M. Klenzler13 BIRTHPLACE OF MOTHER
(State or country)Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ezra Spielman(Address) Hagerstown, Md

15

Filed 11/17, 1915 Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

11 - 16 - 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Nov 15, 1915, to Nov 15, 1915,that I last saw him alive on Nov 15, 1915,and that death occurred on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH* was as follows:

ParalysisContributory
SecondaryAge

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

W. M. Klenzler, M. D.11-16 - 1915 (Address) Hagerstown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boonsboro MdNov 18, 1915

20 UNDERTAKER

ADDRESS

Kraiss BrosHagerstown Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dug laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonacum, etc., *Carcinoma*, *Sarcoma*, etc., of: (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
DEC - 7 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Wash.</u>		19882 ✓	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>755 Concord St.</u> 2 nd Ward)		Registration Dist. <u>302</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>M.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>Nov. 19, 1915</u> (Month) (Day) (Year)				
7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____				
9 BIRTHPLACE (State or country) <u>Hagerstown</u>				
PARENTS	10 NAME OF FATHER <u>Geo. R. Skigler</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Wash. Co. Md.</u>			
	12 MAIDEN NAME OF MOTHER <u>Pearl Wayant</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Penn.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. G. R. Skigler</u> (Address) <u>755 Concord St. Hag.</u>				
15 Filed <u>11/23, 1915</u> <u>Henry Davis</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>11 19, 1915</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov. 19, 1915</u> to <u>Nov 19, 1915</u> , that I last saw him alive on <u>St. 11 Born</u> , 1915, and that death occurred on the date stated above, at <u>8 p.m.</u> The CAUSE OF DEATH* was as follows: <u>Still Born - Six mos. gestation</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>prolapse of arm.</u> (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>H. D. Campbell</u> , M. D. <u>Nov 20, 1915</u> (Address) <u>Hagerstown Md.</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. in the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Hagerstown Md</u> DATE OF BURIAL <u>11/24, 1915</u>				
20 UNDERTAKER <u>Father</u> ADDRESS <u>Hagtu. Md</u>				

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic atelular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
DEC -7 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u>		19883		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Big Pool</u> (No. <u>93</u>)		St. _____ Ward _____		Registration Dist. No. <u>314</u>	
2 FULL NAME <u>John L. Sprecher</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>Oct 21</u> , 1872 (Month) (Day) (Year)		16 DATE OF DEATH <u>Nov 29th</u> , 1915 (Month) (Day) (Year)			
7 AGE <u>43</u> yrs. <u>1</u> mos. <u>8</u> ds.		17 I HEREBY CERTIFY, That I attended deceased from <u>July 27th</u> , 1915, to <u>Nov 29th</u> , 1915, that I last saw him alive on <u>Nov 12th</u> , 1915, and that death occurred on the date stated above, at <u>7:30</u> a.m.			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		The CAUSE OF DEATH* was as follows: <u>Pleuritic wheezes of Right Side</u>			
9 BIRTHPLACE (State or country) <u>Washington Co</u>		(Duration) _____ yrs. _____ mos. _____ ds.			
PARENTS	10 NAME OF FATHER <u>Jacob Sprecher</u>	Contributory _____ Secondary _____			
	11 BIRTHPLACE OF FATHER (State or country) <u>Washington</u>	(Duration) _____ yrs. _____ mos. _____ ds.			
	12 MAIDEN NAME OF MOTHER <u>Mary Young</u>	(Signed) <u>Jonathan P. Perry</u> , M. D. <u>Nov 29th</u> , 1915 (Address) <u>Clear Spring, Md</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Washington</u>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)					
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.					
Where was disease contracted, If not at place of death? _____					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Rose Hill Clear Spr</u>					
DATE OF BURIAL <u>Dec 1</u> , 1915					
20 UNDERTAKER <u>Frank B. Brooks</u>					
ADDRESS <u>Clear Spring</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs John Sprecher</u> (Address) <u>Big Pool R.D.</u>					
15 Filed <u>Nov 29</u> , 1915 <u>W. B. Hull</u> REGISTRAR					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

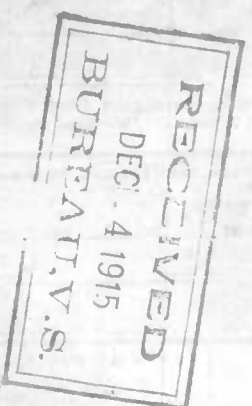
Approved by U. S. Census and American Public Health Association.¹

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

19884

County

Washington

79

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

2

Village or City

Hagerstown (No. 815, S. Polomac St.; 2nd Ward)St.; 2nd Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Martha E. Springer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH March 12, 1871
(Month) (Day) (Year)

7 AGE 44 yrs. 8 mos. 10 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) MD

10 NAME OF FATHER Simon Swope

11 BIRTHPLACE OF FATHER (State or country) MD

12 MAIDEN NAME OF MOTHER Sarah Cross

13 BIRTHPLACE OF MOTHER (State or country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Springer(Address) Hagerstown MD

15 Filed 11/24, 1915 Henry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 22, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 11-22, 1915, to 11-22, 1915.

that I last saw her alive on 11-22, 1915.

and that death occurred on the date stated above, at 11:30 am.

The CAUSE OF DEATH* was as follows:

Heart Disease?
I found her dead
with history of having
Contributor
Heart Disease
(Duration) yrs. mos. ds.
(Signed) Wm. Preston Miller, M.D.
11-22, 1915

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hagerstown MD Nov 24, 1915

20 UNDERTAKER ADDRESS

A. P. Cozzaman Hagerstown MD

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

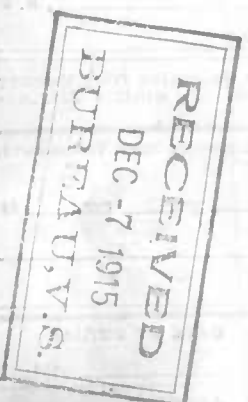
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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Washington</u>		19885	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. _____)		St.; <u>2</u> Ward		Registration Dist. No. <u>302</u>
2 FULL NAME <u>Stclair</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)		
6 DATE OF BIRTH <u>Nov 26</u> , 191 <u>5</u> (Month) (Day) (Year)	7 AGE <u>misarranged</u> yrs. <u>2</u> mos. <u>0</u> ds. OR <u>1</u> yr. <u>1</u> mos. <u>0</u> ds.			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country)				
PARENTS	10 NAME OF FATHER <u>Victor Stclair</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>md</u>			
	12 MAIDEN NAME OF MOTHER <u>Ella Mcmurray</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Pa</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (Address) _____				
15 Filed <u>12/16</u> , 191 <u>5</u> <u>Henry Davis</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Nov 26</u> , 191 <u>5</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 26</u> , 191 <u>5</u> , to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:				
Contributory (Duration) _____ yrs. _____ mos. _____ ds. Secondary (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>W. B. Wood</u> , M. D. _____, 191____ (Address) <u>Hagerstown</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL			DATE OF BURIAL _____, 191____	
20 UNDERTAKER			ADDRESS	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

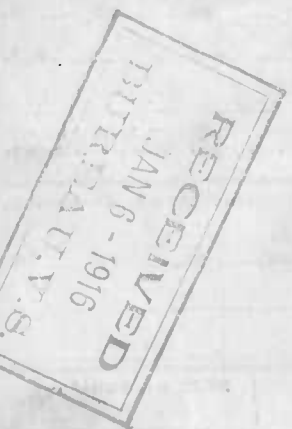
[Approved by U. S. Census and American Public Health
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Washington

19886

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

202

Village or City

Hagerstown

(No.)

336, S Potomac

St.;

3 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ella A. Stork

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Oct 17, 1860
(Month) (Day) (Year)

7 AGE

30 yrs. 1 mos. 9 ds.

If LESS than
1 day... hrs.
OR... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Md

PARENTS

10 NAME OF FATHER

John W. Bray

11 BIRTHPLACE OF FATHER
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Kate Most

13 BIRTHPLACE OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Stork

(Address)

Hagerstown Md.

15

Filed

11/27-1915 Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 26, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov 12, 1915, to Nov 26, 1915,

that I last saw him alive on Nov 24, 1915,

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH was as follows:

Myocarditis
Rheumatism
Anasarca of Effusion
(Duration) yrs. mos. ds.

Contributory
Secondary

(Signed) E. C. McVeigh, M. D.
Nov 26, 1915 (Address) 136 N. Main

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill

11/29, 1915

20 UNDERTAKER

ADDRESS

Hatteries & Minnich Hagerstown Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

561
291 b1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

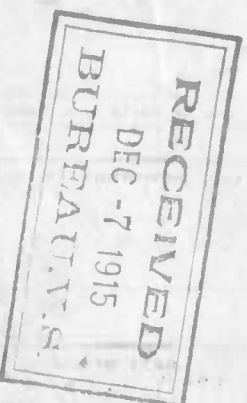
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plauter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Mill engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tramia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telorus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u> 19887 (38) ✓			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Hyattstown</u> (No. <u>Wash. Co. Hospital</u> St.; <u>3</u> Ward)			Registration Dist. No. <u>302</u>		
2 FULL NAME <u>Elizabeth Tall.</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>Nov - 12</u> , 18 <u>67</u> (Month) (Day) (Year)					
7 AGE <u>48</u> yrs. <u>11</u> mos. <u>27</u> ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housemaid.</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>"</u>					
9 BIRTHPLACE (State or country) <u>Maryland.</u>					
PARENTS	10 NAME OF FATHER <u>Jerome Breichner</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Amanda Moll</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. Amanda Breichner</u> (Address) <u>Emmitsburg, Md.</u>					
15 Filed <u>11/10</u> , 191 <u>5</u> <u>Henry Davis</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>11</u> <u>18</u> , 191 <u>5</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct. 15</u> , 191 <u>5</u> , to <u>Nov 8</u> , 191 <u>5</u> , that I last saw him alive on <u>Nov. 8</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>9 p.</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic Nephritis</u> (Duration) <u>1</u> yrs. <u></u> mos. <u></u> ds.					
Contributory Secondary (Duration) <u></u> yrs. <u></u> mos. <u></u> ds.					
(Signed) <u>W. D. Campbell</u> , M. D. <u>Nov. 9</u> , 191 <u>5</u> (Address) <u>Hyattstown Md.</u>					
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u></u> yrs. <u></u> mos. <u></u> ds. In the State, <u></u> yrs. <u></u> mos. <u></u> ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Rose Hill</u>					DATE OF BURIAL <u>11-11th</u> , 191 <u>5</u>
20 UNDERTAKER <u>C. M. Suter & Son, Hyattstown, Md.</u>					ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

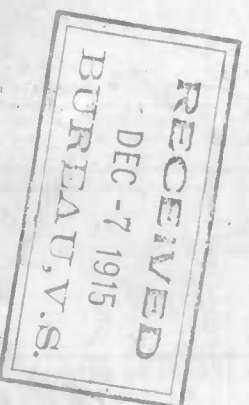
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each, and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonymy is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *men-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reinher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Washington</u>			Registration Dist. No. <u>302</u>	
Village or City <u>Hagerstown</u> (No. <u>Calvert Apts</u> St.; <u>2</u> Ward)			[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Mary Findlay Van Lear.</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		
6 DATE OF BIRTH <u>Sept 14, 1843</u> (Month) (Day) (Year)				
7 AGE <u>72</u> yrs. <u>2</u> mos. <u>8</u> ds. If LESS than 1 day, hrs. OR min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>"</u>				
9 BIRTHPLACE (State or country) <u>Penn.</u>				
PARENTS				
10 NAME OF FATHER <u>John K. Findlay</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Penn.</u>				
12 MAIDEN NAME OF MOTHER <u>Susan Ogilby</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Penn.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. W. Van Lear</u> (Address) <u>Wilmington Del.</u>				
15 Filed <u>11/24, 1915</u> <u>5 Henry Davis</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>November 22nd, 1915</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 21, 1915</u> , to <u>Nov 22, 1915</u> , that I last saw her alive on <u>Nov 22, 1915</u> , and that death occurred on the date stated above, at <u>6 P. M.</u>				
The CAUSE OF DEATH * was as follows: <u>Stroke by bicycle fracture base of skull due to having been hurled to street by bicycle, hemorrhage causing paralysis of left side of face & deglutition (Burellion)</u> yrs. <u>1 1/2</u> mos. <u>11 1/2</u> ds.				
Contributory Secondary				
(Signed) <u>J. W. Humm</u> <u>Physician</u> <u>Nov 24, 1915</u> (Address) <u>Hagerstown, Md.</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Williamsports Md</u>				DATE OF BURIAL <u>11/24, 1915</u>
20 UNDERTAKER <u>Edw. Suter Son</u>				ADDRESS <u>Hagerstown</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

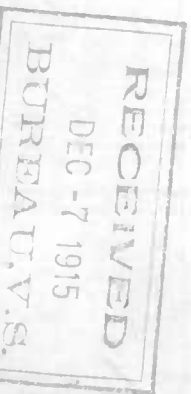
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Miasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reinforced wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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19889

1 PLACE OF DEATH

County

Washington

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 306

Village or City

Crystal Falls

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William M. Maltz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

1848

(Month)

(Day)

(Year)

7 AGE

67

yrs.

mos.

ds.

If LESS than 1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Daniel Maltz

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sallie Sanders

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fannie Maltz

(Address)

Smithsburg

15

Filed Nov. 10, 1915 J. H. Ferguson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 9

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Oct 30, 1915 to Nov 9, 1915

that I last saw him alive on Nov 9, 1915

and that death occurred on the date stated above, at 2-106 m.

The CAUSE OF DEATH* was as follows:

Heart failure, secondary following exhaustion from typhoid fever. His heart had been for 2 yrs. (Duration) yrs. 6 mos. 4 ds.

Contributory

Was extreme weakness from fever (Duration) yrs. 1 mos. 4 ds.

(Signed)

J. L. Messie, M. D.

Nov. 9, 1915 (Address) Smithsburg

*State the DISEASE CAUSING DEATH, or deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, Crystal Falls

If not at place of death?

Former or usual residence Crystal Falls

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Crystal Falls

Nov. 4, 1915

20 UNDERTAKER

ADDRESS

William L. Brown Smithsburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accidental*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Wash.</u> 19890		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Rockersville</u> (No. <u>9</u>)		Registration Dist. No. <u>307</u>	
2 FULL NAME <u>Gladys</u> <u>Wilman</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)	
6 DATE OF BIRTH <u>4</u> <u>26</u> , 191 <u>3</u> (Month) (Day) (Year)			
7 AGE <u>2</u> yrs. <u>6</u> mos. <u>12</u> ds.		If LESS than 1 day,.....hrs. OR.....min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>			
9 BIRTHPLACE (State or country) <u>Ind</u>			
PARENTS	10 NAME OF FATHER <u>John Wilman</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u>		
	12 MAIDEN NAME OF MOTHER <u>Jessie Haynes</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Dr. C. D. Baker</u> (Address) <u>Rockersville, Ind</u>			
15 Filed <u>Apr 8</u> , 191 <u>3</u> <u>C. D. Baker</u> <u>Ind</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Apr</u> <u>8</u> , 191 <u>3</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Apr 1</u> , 191 <u>3</u> , to <u>Apr 8</u> , 191 <u>3</u> , that I last saw him alive on <u>Apr 8</u> , 191 <u>3</u> , and that death occurred on the date stated above, at <u>5:30 a.m.</u> The CAUSE OF DEATH* was as follows: <u>Diphtheria</u>			
(Duration) yrs. mos. ds.			
Contributory Secondary (Duration) yrs. mos. ds.			
(Signed) <u>C. D. Baker</u> , M. D. , 191..... (Address) <u>Rockersville, Ind</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence.			
19 PLACE OF BURIAL OR REMOVAL <u>Rockersville, Ind</u>		DATE OF BURIAL <u>Apr 9</u> , 191 <u>3</u>	
20 UNDERTAKER <u>C. L. German & Co</u>		ADDRESS <u>Rockersville, Ind</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			19891		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Washington</u>			70		Registered No. <u>303</u>	
Village or City <u>Spickler</u> (No. _____) St; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]						
FULL NAME <u>John E. Yeakle</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)				
6 DATE OF BIRTH <u>Oct 30</u> , 18 <u>80</u> (Month) (Day) (Year)						
7 AGE <u>65</u> yrs. <u>0</u> mos. <u>28</u> ds. If LESS than 1 day, _____ hrs. OR _____ min. ?						
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)						
9 BIRTHPLACE (State or country) <u>Franklin Co. Pa.</u>						
PARENTS	10 NAME OF FATHER <u>George Yeakle</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Franklin Co Pa</u>					
	12 MAIDEN NAME OF MOTHER <u>Rehanna Miller</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Franklin Co Pa.</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Nellie Yeakle</u> (Address) <u>Clear Spring R. Dr.</u>						
15 Filled <u>Nov 20</u> , 191 <u>5</u> <u>Martin Boward</u> REGISTRAR						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>November 28</u> , 191 <u>5</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept 19</u> , 191 <u>5</u> , to <u>Nov. 28</u> , 191 <u>5</u> . that I last saw him alive on <u>Nov. 28</u> , 191 <u>5</u> .						
and that death occurred on the date stated above, at <u>6</u> P.m., The CAUSE OF DEATH* was as follows: <u>Cardiac dilatation</u> (Duration) _____ yrs. <u>3</u> mos. _____ ds.						
Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.						
(Signed) <u>Theo. Poose</u> , M. D. <u>Nov. 29</u> , 191 <u>5</u> (Address) <u>Williamsport, Md.</u>						
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.						
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>St Pauls Cemetery</u>						DATE OF BURIAL <u>Dec 1</u> , 191 <u>5</u>
20 UNDERTAKER <u>Franky Brown & Co</u>						ADDRESS <u>Clear Spring</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Vraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—deceased*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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